

<u>Introduction</u>

- Overview
- How to Complete the DEEOIC Authorization Templates :
 - Durable Medical Equipment (DME)
 - General Medical
 - Home Health
 - Rehab
 - Transplant
 - Medical Transportation
- Authorization Submission Methods



Overview

When claimants are treated for their work-related injuries and/or occupational diseases, certain services require an authorization. Providers must submit the appropriate authorization template. Authorizations must be approved for such services rendered before any payments can be reimbursed.

Services that require authorization are categorized by levels. Level 3 services will require completion of an authorization template. To determine if a service requires an authorization, visit the Office of Workers' Compensation Programs, Medical Bill Processing Portal at https://owcpmed.dol.gov or you can speak with a customer service representative at 844-493-1966 beginning April 27, 2020.

The new authorization templates have been changed and will be available <u>view only</u> beginning April 13, 2020, on the pre-go-live Portal at https://prod.wcmbp.com/outreach/.

Note: The authorization templates will not be available for submission until April 27, 2020.

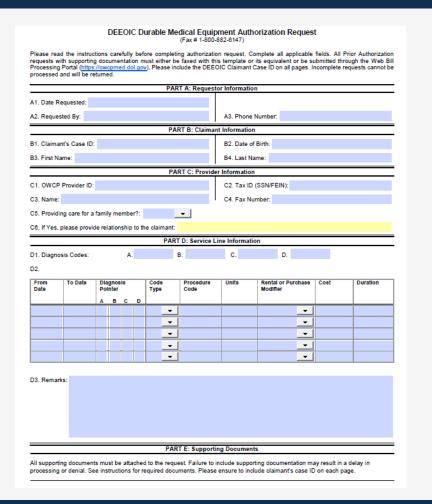


Durable Medical Equipment Template



Durable Medical Equipment Template

Durable Medical Equipment that are level's 2 or 3, will require the completion of a DME Authorization Template.





PART A: Requestor Information					
A1. Date Requested:					
A2. Requested By:		A3. Phone Number:			

- **A1.** Enter the date the authorization is being completed.
- **A2.** Enter the name of the person requesting the authorization.
- **A3.** Enter the phone number of the person requesting the authorization. (Not Required)

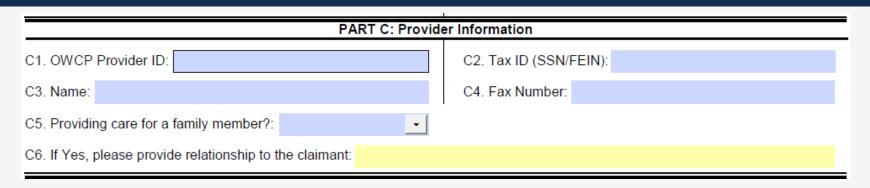


- **B1.** Enter the Claimant's 9 digit Case ID.
- **B2.** Enter the Date of Birth (mm/dd/yyyy).
- **B3.** Enter the Claimant's First Name.
- **B4.** Enter the Claimant's Last Name.

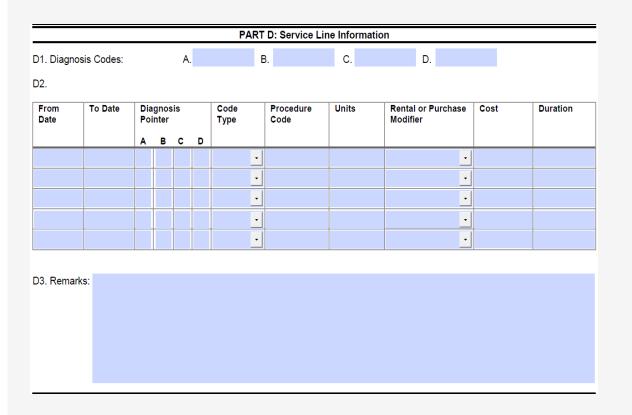
Note: All fields in Part B are required.

PART B: Claimant Information					
B1. Claimant's Case ID:	B2. Date of Birth:				
B3. First Name:	B4. Last Name:				





- **C1.** Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- **C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.
- C3. Enter the Provider's Name.
- **C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. (**Not Required**)
- **C5.** Confirm if you are providing care for a family member or not.
- **C6.** If you are providing care, state your relationship to the claimant. (Only required if Yes was selected in C5)



D1. Up to four ICD-9 or ICD-10 codes can be entered.

• ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

D2.

- Enter the DOS range.
- Enter the Diagnosis you want to point to from D1, multiple pointers can be selected.
- Select the Code Type (HCPCS).
- Enter the Procedure Code (HCPCS).
- Enter the Units requested.
- Select RR (for Rental), NU (for Purchased New) or EU (for Purchased Used).
- Enter the total Cost for the full DOS range.
- Enter duration (Required For Rentals Only).

D3. Enter any additional notes you may have (Not Required).



PART E: Supporting Documents

All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. See instructions for required documents. Please ensure to include claimant's case ID on each page.

Letter of medical necessity, prescription and information regarding the requested equipment along with how it meets the physician's prescription.

* Write the Claimant's Case ID on all additional pages submitted with the template.

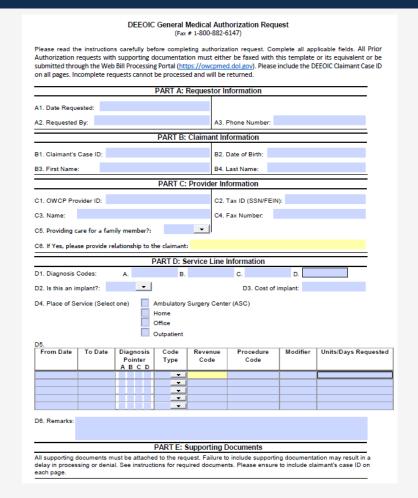


General Medical Template



General Medical Template

General Medical Services that are level 2 or 3, will require the completion of a General Medical Authorization Template.





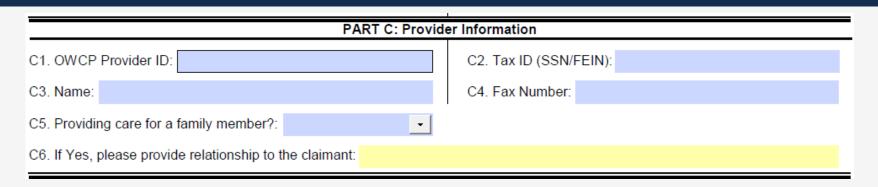
PART A: Requestor Information					
A1. Date Requested:					
A2. Requested By:		A3. Phone Number:			

- **A1.** Enter the date the authorization is being completed.
- **A2.** Enter the name of the person requesting the authorization.
- **A3.** Enter the phone number of the person requesting the authorization. (Not Required)

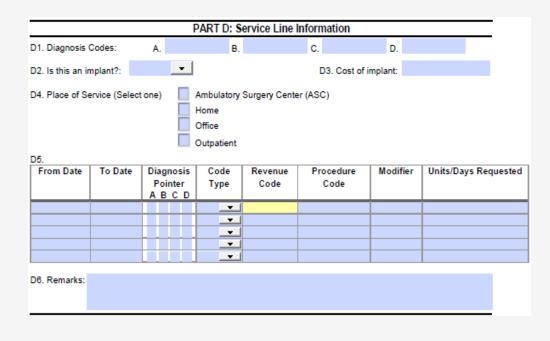
- **B1.** Enter the Claimant's 9 digit Case ID.
- **B2.** Enter the Date of Birth (mm/dd/yyyy).
- **B3.** Enter the Claimant's First Name.
- **B4.** Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information					
B1. Claimant's Case ID:	B2. Date of Birth:				
B3. First Name:	B4. Last Name:				



- **C1.** Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- **C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.
- C3. Enter the Provider's Name.
- **C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. (**Not Required**)
- **C5.** Confirm if you are providing care for a family member or not.
- C6. If you are providing care, state your relationship to the claimant. (Only required if Yes was selected in C5)



- **D1.** Up to four ICD-9 or ICD-10 codes can be entered.
 - ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.
- **D2.** State if this is an implant?
- **D3.** If this is for an implant, how much does it cost?
- **D4.** Select the place were service was rendered.

D5.

- Enter the DOS range.
- Enter the Diagnosis you want to point to from D1, multiple pointers can be selected.
- Select the code type (CPT/HCPCS/RCC/NDC) **Note:** Select Revenue Code type for Outpatient Facility services as per instructions.
- Enter Revenue Code if applicable.
- Enter Procedure Code (CPT, HCPCS or NDC).
- Enter the code Modifier (if applicable).
- Enter Units Requested.
- **D6.** Enter any additional remarks.



Attach any supporting documentation that may help. (Not required)

* Write the Claimant's Case ID on all additional pages submitted with the template.

PART E: Supporting Documents

All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. See instructions for required documents. Please ensure to include claimant's case ID on each page.



Home Health Template

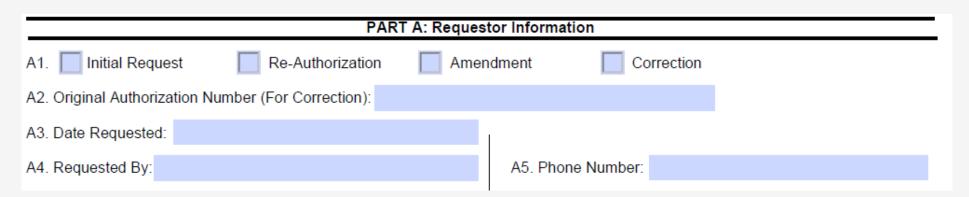


Home Health Template

Home Health Services that are level 3, will require the completion of the Home Health Template.

					PART	A: Request	or Infe	ormation			
A1. Initial	Request	Re	-Autho			Amen			Correctio	n	
A2. Original Au	thorization Nu	mber (Fo	Corre	ection)	:						
A3. Date Requ	ested:										
A4. Requested	By:						A5.	Phone Numbe	r.		
					PAR	TB: Claimar	nt Info	rmation			
B1. Claimant's	Case ID:						B2.	Date of Birth:			
B3. First Name:					B4.	Last Name:					
					PAR	ΓC: Provide	r Info	rmation			
C1. OWCP Pro	ovider ID:						C2.	Tax ID (SSN/F	EIN):		
C3. Name:							C4.	Fax Number:			
			r?:			-					
C5. Providing of	care for a famil	y membe									
_	care for a family ase provide rela			claima	ant:						
_						D: Service P	lan In	formation			
_	ase provide rela				ART	D: Service P	'lan In	formation			
C8. If Yes, plea	ase provide rela			P	ART	D: Service P	lan In	formation E).		
C6. If Yes, ples D1. Service Ty D2. Diagnosis D3.	ase provide rela rpe: Codes:	ationship A.	to the	P	B.		C.	E		uration	Tatal light
C6. If Yes, ples D1. Service Ty D2. Diagnosis	ase provide rela	ationship A.	to the	Pointer	B.	Procedure Code	'lan In			uration	Total Units Request
C6. If Yes, ples D1. Service Ty D2. Diagnosis D3.	ase provide rela rpe: Codes:	A.	to the	P	B.	Procedure	C.	E		uration	
C6. If Yes, ples D1. Service Ty D2. Diagnosis D3.	ase provide rela rpe: Codes:	A.	to the	Pointer	B.	Procedure	C.	E		uration	
C6. If Yes, ples D1. Service Ty D2. Diagnosis D3.	ase provide rela rpe: Codes:	A.	to the	Pointer	B.	Procedure	C.	E		uration	
C6. If Yes, ples D1. Service Ty D2. Diagnosis D3.	ase provide rela rpe: Codes:	A.	to the	Pointer	B.	Procedure	C.	E		uration	





A1. Select an option:

- Initial Request (new or first time requesting an authorization).
- Re-Authorization (to request the same level of care as the previous request).
- Amendment (to request a different level of care).
- Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

- **A3.** Enter the date the authorization is being completed.
- **A4.** Enter the name of the person requesting the authorization.
- **A5.** Enter the phone number of the person requesting the authorization. (**Not Required**)



B1. Enter the Claimant's 9 digit Case ID (listed on the front of the new MBIC).

B2. Enter the Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information					
B1. Claimant's Case ID:	B2. Date of Birth:				
B3. First Name:	B4. Last Name:				

PART C: Provider Information						
C1. OWCP Provider ID:	C2. Tax ID (SSN/FEIN):					
C3. Name:	C4. Fax Number:					
C5. Providing care for a family member?:						
C6. If Yes, please provide relationship to the claimant:						

- **C1.** Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- **C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.
- **C3.** Enter the Provider's Name.
- **C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider's profile, it can be left blank. (**Not Required**)
- **C5.** Confirm if you are providing care for a family member or not.
- C6. If you are providing care, state your relationship to the claimant. (Only required if Yes was selected in C5.)



- **D1.** Select the Service Type (Assisted Living, HHC, Hospice or Nursing Home).
- **D2.** Up to four ICD-9 or ICD-10 codes can be entered.
 - ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

D3.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select the applicable HH code from the available options.
- Enter the Frequency (How many times a week will the claimant be seen?)
- Enter the Duration (How many total weeks will the claimant be seen?)
- Enter the Total Units Requested (Frequency x Duration = Total Units Requested)
- **D4.** Enter any additional remarks



Letter of medical necessity, evidence of face to face exam, plan of care, and any other medical documentation supporting the need for care as it relates to the accepted condition(s).

* Write the Claimant's Case ID on all additional pages submitted with the template.

PART E: Supporting Documents

All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. See instructions for required documents. Please ensure to include Claimant's Case ID on each page.

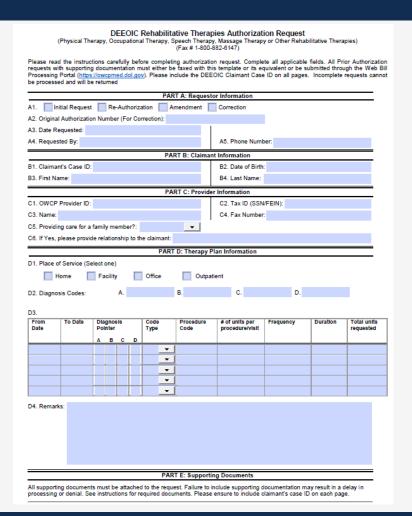


Rehabilitative Therapies Template

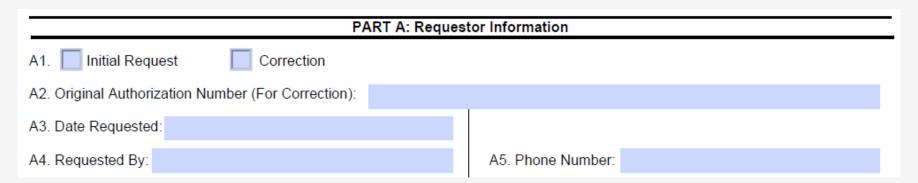


Rehabilitative Therapies Template

Providers that are rendering Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy or other Rehabilitative Therapies will require the completion of a Rehabilitative Therapies Authorization Template.







A1. Select an option:

- Initial Request (new or first time requesting an authorization).
- Correction (to update or correct an authorization that is currently on file).
- **A2.** If making a correction to an authorization that is on file, list the authorization number that is on file.
- **A3.** Type the date the authorization is being completed.
- **A4.** Enter the name of the person requesting the authorization.
- A5. Enter the phone number of the person requesting the authorization. (Not Required)

- **B1.** Enter the Claimant's 9 digit Case ID.
- **B2.** Enter the Date of Birth (mm/dd/yyyy).
- **B3.** Enter the Claimant's First Name.
- **B4.** Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information					
B1. Claimant's Case ID:	B2. Date of Birth:				
B3. First Name:	B4. Last Name:				

PART C: Provider Information							
C1. OWCP Provider ID:	C2. Tax ID (SSN/FEIN):						
C3. Name:	C4. Fax Number:						
C5. Providing care for a family member?:							
C6. If Yes, please provide relationship to the claimant:							

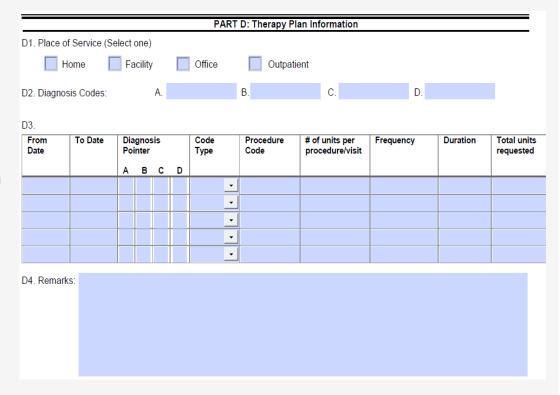
- C1. Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- **C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.
- **C3.** Enter the Provider's Name.
- **C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. (**Not Required**)
- **C5.** Confirm if you are providing care for a family member or not.
- C6. If you are providing care, state your relationship to the claimant. (Only required if Yes was selected in C5)

- **D1.** Select a Place of Service (Home, Facility, Office or Outpatient).
- **D2.** Up to four ICD-9 or ICD-10 codes can be entered.
 - ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

D3.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select code type (CPT/HCPCS/Revenue Code/NDC Code).
- Enter the Procedure Code.
- Enter the # of Units Per Procedure/Visit (1 unit = 15 mins).
- Enter the frequency (How many times a week will the claimant be seen?)
- Enter the duration (How many total weeks will the claimant be seen?)
- Enter the total units requested (# of Units Per Procedure x Frequency x Duration = Total Units Requested).

D4. Enter any additional remarks.



Transplant Template



Transplant Template

Transplants will require the completion of a DEEOIC Transplant Authorization Template.

DEEOIC Transplant Authorization Request (Fax # 1-800-882-6147) Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prior Authorization requests with supporting documentation must either be faxed with this template or its equivalent or be submitted through the Web Bill Processing Portal (https://owcomed.doi.gov). Please include the DEEOIC Claimant Case ID on all pages. Incomplete requests cannot be processed and will be returned.										
PART A: Requestor Information										
A1. Date Requested:										
A2. Requested By:					A3. Phon	e Number:				
	PART B: Claimant Information									
B1. Claimant's Case ID	B1. Claimant's Case ID:					B2. Date of Birth:				
B3. First Name:						B4. Last Name:				
B5. Authorized Represe	entative:				B8. Phone Number:					
		PAF	RT C: Pro	vider I	nformatio	on .				
C1. OWCP Provider ID):					D (SSN/FEIN):			
C3. Name:					C4. Fax N	Number:				
		PART D:	Treating	Physic	cian Infor	mation				
D1. Treating Physician:	:			,						
D2. Treating Physician										
		DADT	E: Servi	oo Line	Informa	fion				
E1. Diagnosis Codes:	A		B.	oc Elin	C.	-	D.			
E2. From Date	To Date	Diagnos	ls Pointer			Code Type		Procedure Code		
		A	В	С	D					
							_ +			
							-			
							-			
E3. Remarks: PART F: Transplant Information										
E1 Teacelast Exciling		FAR	I F. IIali	Spianic						
F3. Transplant Facility	F1. Transplant Facility: F2. Transplant Type:									
F4: Transplant Facility										
F5. Organ Transplant Coordinator Name: F6. Phone Number:										
PART G: Supporting Documents All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. See instructions for required documents. Please ensure to include claimant's case ID on each page. Required documentation: Letter of medical necessity from the treating physician describing the need for the transplant being requested.										
Initial and recent clinical evaluation (i.e., diagnostic studies and laboratory tests) A copy of the treatment protocol										



PART A: Requestor Information				
A1. Date Requested:				
A2. Requested By:	A3. Phone Number:			

- **A1.** Enter the date the authorization is being completed.
- **A2.** Enter the name of the person requesting the authorization.
- **A3.** Enter the phone number of the person requesting the authorization. (Not Required)

- **B1.** Enter the Claimant's 9 digit Case ID (listed on the front of the new MBIC).
- **B2.** Enter the Date of Birth (mm/dd/yyyy).
- **B3.** Enter the Claimant's First Name.
- **B4.** Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information					
B1. Claimant's Case ID:	B2. Date of Birth:				
B3. First Name:	B4. Last Name:				
B5. Authorized Representative:	B6. Phone Number:				



PART C: Provider Information	
C1. OWCP Provider ID:	C2. Tax ID (SSN/FEIN):
C3. Name:	C4. Fax Number:

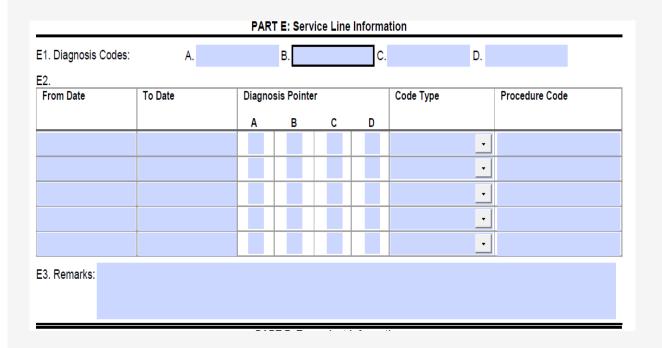
- **C1.** Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- **C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.
- C3. Enter the Provider's Name.
- **C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider's profile, it can be left blank. (**Not Required**)

D1. Enter the Treating Physician's name.

D2. Enter the Treating Physician's Address.

PART D: Treating Physician Information	
D1. Treating Physician:	
D2. Treating Physician Address:	

Completing the Transplant Template



E1. Up to four ICD-9 or ICD-10 codes can be entered.

• ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

E2.

- Enter the DOS range.
- Select the Diagnosis you want to point to from E2, multiple pointers can be selected.
- Select if the code is a HCPCS or CPT code.
- Enter the Procedure Code.

E3. Enter any additional remarks.



Completing the Transplant Template

PART F: Transplant Information			
F1. Transplant Facility:	F2. Transplant Type:		
F3. Transplant Facility Address:			
F4: Transplant Facility Phone:			
F5. Organ Transplant Coordinator Name:	F6. Phone Number:		

- **F1.** Enter the name of the Transplant Facility.
- **F2.** Enter the type of Transplant being done.
- F3. Enter the Transplant Facility Address.
- **F4.** Enter the Transplant Facility Phone number.
- **F5.** Enter the name of the person coordinating the organ transplant.
- **F6.** Enter the coordinator's Phone Number.



Completing the Transplant Template

PART G: Supporting Documents

All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. See instructions for required documents. Please ensure to include claimant's case ID on each page.

Required documentation:

- Letter of medical necessity from the treating physician describing the need for the transplant being requested.
- Initial and recent clinical evaluation (i.e., diagnostic studies and laboratory tests)
- A copy of the treatment protocol

All supporting documentation is required.

* Write the Claimant's Case ID on all additional pages submitted with the template.

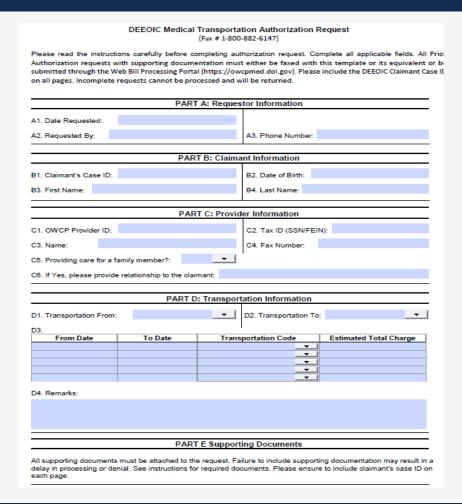
Medical Transportation Template



Medical Transportation Template

Providers rendering the below travel services will require the completion of a Travel Template:

- A0100 Taxi
- **A0110** Bus, intra- or interstate carrier
- A0120 Mini-Bus, mountain area transports, and other transports
- A0130 Wheelchair Van





PART A: Requestor Information			
A1. Date Requested:			
A2. Requested By:	A3. Phone Number:		

- **A1.** Enter the date the authorization is being completed.
- **A2.** Enter the name of the person requesting the authorization.
- A3. Enter the phone number of the person requesting the authorization. (Not Required)

B1. Enter the Claimant's 9 digit Case ID (listed on the front of the new MBIC).

B2. Enter the Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information		
B1. Claimant's Case ID:	B2. Date of Birth:	
B3. First Name:	B4. Last Name:	

PART C: Provider Information				
C1. OWCP Provider ID:	C2. Tax ID (SSN/FEIN):			
C3. Name:	C4. Fax Number:			
C5. Providing care for a family member?:				
C6. If Yes, please provide relationship to the claimant:				

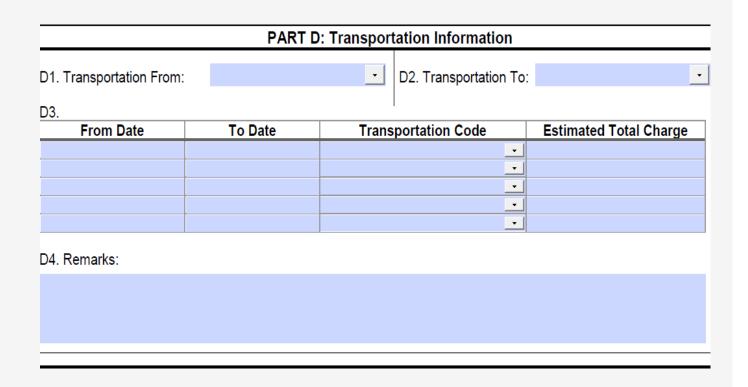
- C1. Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- **C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.
- **C3.** Enter the Provider's Name.
- **C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. (**Not Required**)
- **C5.** Confirm if you are providing care for a family member or not.
- C6. If you are providing care, state your relationship to the claimant. (Only required if Yes was selected in C5)

D1. Select the location where your travel started from.

D2. Select the location where your travel ended.

D3.

- Enter the travel From and To date.
- Select the Transportation Code (A0100/A0110/A0120/A0130).
- Enter the Estimated Total Charge amount.
- **D4.** Enter any additional remarks.





Attach receipts or invoices to confirm the estimated total charge.

* Write the Claimant's Case ID on all additional pages submitted with the template.

PART E Supporting Documents

All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. See instructions for required documents. Please ensure to include claimant's case ID on each page.



Authorization Submission Methods

Authorization Templates can be submitted via:

- **Direct Data Entry (DDE)** in the Workers' Compensation Medical Bill Processing (WCMBP) System.
- **Fax** at 800.882.6147.
- Mail to PO Box 8304 London, KY 40742-8304.

Authorizations are available for status within 1 business days of receipt. To check on your Authorization status, visit the Office of Workers' Compensation Programs, Medical Bill Processing Portal at https://owcpmed.dol.gov or you can speak with a customer service representative at 844-493-1966 beginning April 27, 2020.



THANK YOU!

